Senior Connections

PSYCHOTHERAPY PROGRESS NOTE

Date of Session: ___/___/___ **Primary DX:** ____________________________ **Facility Name:** ___________________
(ICD-Code #) (Disorder Name)

Name of Patient: ____ ______ ☐ Female ☐ Male
(Last) (First) Age

Length of Session: (actual minutes) _________ ☐ No Session ____

Type of Service Billed:

Individual Therapy: ☐ 90832 ☐ 90834 ☐ 90837

Group Therapy: ☐ 90853

Crisis Codes: ☐ 90839 (first 60 minutes) ☐ 90840 x _____ (each additional 30 min of crisis therapy)

Outcome Measurement: ☐ Periodic Treatment Review ☐ Other: ____

Treatment Issue/Target Symptoms/Behaviors On Current Treatment Plan addressed during session:

____

Symptoms Observed During Session:

☐ aggression (physical)
☐ aggression (verbal)
☐ agitation
☐ anger
☐ anhedonia
☐ anxiety/fear
☐ appetite disturbance
☐ danger to others
☐ danger to self
☐ decreased energy/fatigue
☐ delusions
☐ depressed
☐ distractibility
☐ emotional lability
☐ feelings of worthlessness
☐ hallucinations (auditory)
☐ hallucinations (visual)
☐ hopelessness/helplessness
☐ hypersomnia/insomnia
☐ impulsivity
☐ irritability
☐ negative statements
☐ noncompliance (medical care)
☐ restlessness
☐ sad/pained/worried expression
☐ self deprecation
☐ socially inappropriate (specify:_________)
☐ social withdrawal
☐ suicidal ideation or plan
☐ thought disorder (specify:______________)
☐ other observed symptoms:_____________
____

Comorbid medical condition impacting psychological status. Specify: ________________________________

Therapeutic Techniques

☐ Cognitive Behavioral ☐ Insight-oriented ☐ Behavioral Modification ☐ Supportive ☐ Other: _______________

Intervention Strategies Implemented *and* Session **Focus** or **Theme:** ____________________________________

____
____
____

Patient Response

☐ Marked Improvement ☐ Some Improvement ☐ Maintenance of Functioning ☐ Symptoms Worse

Evidence of Patient Response: ____

____
____
____

Future Treatment/Follow-up Issues: ____

____

Check when applicable: ☐ Change Treatment Plan ☐ Change Diagnosis

_________________________________ _________________________________
Signature of Therapist/Title
If signature appears here, signature of the Psychologist verifies direct supervision or presence in same room.

Signature of Psychologist (only)